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INTERIM PROJECT

Transition to Consumer-Driven Health Care

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Executive Summary

Consumers have come to expect service, convenience, selection, quality, and fair price in everything that is purchased. "Consumerism," in health care means making health care plan members more responsible for the decisions that they make, including how they take care of themselves, and requires them to become more aware of the financial ramifications of their decisions.

Health insurance companies have integrated the idea of consumerism into their plans, calling them "consumer-driven health care plans." Consumer-driven health care refers to a plan that is designed to include a high deductible insurance plan, a personal account to pay for care funded in various ways, and an internet-based decision support system. A consumer-driven health plan must offer a high deductible health plan and a tax-advantaged savings account, such as a Health Savings Account (HSA). HSAs are the most common type of consumer-driven health plan. Americans gained access to health savings accounts on January 1, 2004 through federal regulation. Industry predictions indicate that HSAs could number 8.2 million, and hold $50 million in consumer assets by the end of 2010.

Advocates for consumer-driven health plans argue that exposing consumers to quality, selection, and price will force competition in the health care arena. Competition should result in dramatically reduced costs for services of similar quality, and assist in spurring performance improvement initiatives in the health care market.

Critics of consumer-driven health plans argue, consumers may have an incentive to avoid necessary health care, such as preventative care, and shop for services based on price, not quality, value and service.

The way consumers make decisions, access health information, and utilize health care services, impacts the effectiveness of consumer-driven health plans. The industry is currently adopting numerous tools to assist consumers in making informed health care decisions. Inundating consumers with too much information may inadvertently confuse consumers. The health care industry will need to continue to work with consumers to help them make rational informed health care decisions. Additional research is needed to determine the type and size of incentives that encourage consumers to become a more active participant in health care decision making.

CONSUMER-DRIVEN HEALTH CARE

Consumers have come to expect service, convenience, selection, quality, and fair prices in everything that is purchased. "Consumerism" in health care means making health care plan members more responsible for the decisions that they make, including how they take care of themselves, and making them more aware of the financial ramifications of their decisions.[1] Benefit experts define consumerism as a strategy that helps people: adopt and maintain a healthy lifestyle; make informed decisions when they need to access health care; manage their health care funds wisely by such measures as choosing cost-effective providers; and become more active participants in decisions about their own care.[2]

Health insurance plans have integrated consumerism into their plans, calling them "consumer-driven health care plans." Consumer-driven health care refers to a health benefit design that provides consumers with a high deductible insurance plan, a personal account to pay for care funded in various ways, and an internet-based decision support system.[3]

In these plans employees or consumers play a greater role in choosing their own benefit package while assuming greater financial risk.[4] There are slight variations in the meanings and terms such as "consumer-driven health insurance," "consumer-directed health care," "defined contribution health plans," "medical savings accounts,"[5] and "consumer-centric health plans," but they all share the same vision of lowering health care costs by shifting some of the actual cost of health care to consumers.

Marsh/Mercer,[6] one of the world's largest human resources/health benefits consulting firms, defines a consumer-driven health plan as a health benefit plan that incentivizes insurers to select more affordable and/or higher quality health care options, and provides cost and/or quality information with which consumers can compare available options. Similarly, the Academy of Health defines consumer-driven health care as a

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[1] Walsh, Tom. 2004. "Risk Alert: Controlling Health Care Costs." Marsh. Health Care Costs. Vol. 3. Issue 3. http://www.marshweb.com/MarshPortal/resources?id=5610ad7730204bff9225db54f4d61d10 (November 28, 2005).

[2] Ibid.

[3] Gauthier, A. and C. Clancy. 2004. "Consumer-Driven Health Care-Beyond Rhetoric with Research and Experience." Vol. 39. No. 4. Health Services Research. http://www.academyhealth.org/publications/hsr.pdf (November 29, 2005).

[4] Gabel, Jon, R., Anothony T. Lo Sasso and Thomas Rice. 2002. "Consumer-driven Health Plans: Are they more than talk now?" Market Watch. Health Affairs. http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.395v1/DC1 (November 29, 2005).

[5] The medical savings accounts are a type of plan authorized by HIPPA in 1996 that like the new HSAs, has some very specific benefit design elements.

[6] Since 1986, Marsh/Mercer has annually conducted a survey of employer-sponsored health plans. Nearly 3,000 US employers participated in the 2005 National Survey of Employer-Sponsored Health Plans.

model of care that provides financial incentives to consumers to reduce unnecessary health care utilization by increasing their financial risk.[7]

Advocates for consumer-driven health plans argue that exposing consumers to quality, selection, and price will force competition in the health care arena. Competition should result in dramatically reduced costs for services of similar quality and assist in spurring performance improvement initiatives in the health care market. Quality and cost-efficiency vary widely among hospitals, physicians, and different treatment options for the same condition. According to a Mercer/Harvard study[8], the wide performance variation offers substantial opportunity for informed and incentivized consumers to preferentially select better performing physicians, hospitals and treatment options, including better self-management and understanding of health risks and avoidance of services that offer no health value.[9]

The Mercer/Harvard study found that "up to 40% of what Americans currently spend on health care could be eliminated over a 10-year period, and thereby slow the rate of biotechnology-driven health insurance cost increases, without impinging on quality of care, clinical outcomes, or patient satisfaction." The study revealed that early forms of consumer-driven health plans report decreased rates of per capita health spending and increased consumer information seeking; early assessments have not studied the impact on health outcomes or conducted extensive measurements of quality. Plans have reported savings on insurance premiums but they have not fully accounted for a more favorable enrollee health status, leaner covered benefits, cost transfers to sicker beneficiaries or employer-purchaser, nor the economic value of health or quality losses that may unintentionally impact plan enrollees.[10]

The benefits of consumer-driven health care have attracted a great deal of attention. Consumer-driven health care is touted to be the "next big thing" in the health care industry following managed care. According to a white paper published by Financial Research Corporation, Health Savings Accounts (HSAs) could number 8.2 million, and hold $50 million in assets by the end of 2010.

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[7] Marchetta, Monica and Deborah Rogel. 2005. "Issue Brief: Health Savings Accounts as a Tool for Market Change." Vol. 8. No. 4. Academy Health. http://www.hcfo.net/pdf/issue0605.pdf (November 29, 2005).

[8] The study was conducted by Mercer Human Resource Consulting and Harvard School of Public Health, funded by the Robert Wood Johnson Foundation.

[9] U.S. Congress. Joint Economic Committee Testimony. 2004. "Consumer Directed Health Benefit Plans Could Greatly Improve Quality of Care and Health Insurance Affordability; Early Attempts will Fall Considerably Short of Their Potential; There are Budget-Neutral Opportunities for Congress to Help." 108th Congress. http://jec.senate.gov/democrats/Documents/Hearings/milsteintestimony25feb2004.pdf (November 29, 2005).

[10] U.S. Congress. Joint Economic Committee Testimony. 2004. " Consumer Directed Health Benefit Plans Could Greatly Improve Quality of Care and Health Insurance Affordability; Early Attempts will Fall Considerably Short of Their Potential; There are Budget-Neutral Opportunities for Congress to Help." 108th Congress. http://jec.senate.gov/democrats/Documents/Hearings/milsteintestimony25feb2004.pdf (November 29, 2005).

Critics of consumer-driven health plans argue that consumers may have an incentive to avoid necessary health care, such as preventative care and shop for services based on price, not quality, value and service.

How Consumer-driven Health Care Differs from Managed Care

Managed care brought about a major change in the way health care is delivered by providers and utilized by patients. The purpose of managed care is similar to consumer-driven health care; both strive to increase efficiency and reduce health care costs. The difference is that managed care focuses financial incentives on the insurers and providers of health care services, while consumer-driven health care focuses financial incentives on the consumer along with tax breaks.

The goals of managed care include: enhanced cost containment, some form of rationing, administrative and clinical efficiency, reduced duplication of services, enhanced appropriateness of care, comprehensive contracting mechanisms, and improved care, by managing provider and consumer behavior.[11] In managed care the primary care physician acts like a 'gatekeeper' who controls the patient's use of expensive resources and reduces the rate of self-initiated use of costly specialty care. In consumer-driven health plans the 'gatekeeper' is the consumer. Consumers are expected to regulate their own health care expenses.

Consumer-driven health care plans generally are able to offer lower premiums to consumers. A study of 23 companies offering consumer-driven health plans revealed that the average premium was $36 per month for single coverage and $145 per month for family coverage.[12] The average premium for a preferred provider organization (PPO) plan was $66 for single coverage and $224 for family coverage; and a health maintenance organization (HMO) plan was $54 for single coverage and $200 for family coverage. The tradeoff for the lower premiums associated with a consumer-driven health plan is a higher deductible and the necessity to take responsibility for their own health care decisions.[13]

TYPES OF CONSUMER-DRIVEN HEALTH CARE PLANS

A consumer-driven health plan must have two components: a high deductible health plan and a tax-advantaged savings account. The health savings account is the newest type of account. While consumer-driven health plans are commonly called HSAs, there are actually several different types of tax advantaged accounts. They include Medical Savings Accounts (MSAs), Health Reimbursement Arrangements (HRAs), and Health

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[11] Williams, Stephen J. and Paul R. Torrens. 2002. *Introduction to Health Services.* 6th edition. Albany, NY: Delmar Publishing.
[12] Walsh, Tom. 2004. "Risk Alert: Controlling Health Care Costs." Marsh. Health Care Costs. Vol. 3. Issue 3. http://www.marshweb.com/MarshPortal/resources?id=5610ad7730204bff9225db54f4d61d10 (November 28, 2005).
[13] Ibid.

Savings Accounts (HSAs).[14] The difference between these is how they are established in the tax code. Four types of tax-advantaged accounts are permitted under current law: Flexible Spending Accounts, Medical Savings Accounts, Health Reimbursement Accounts, and Health Savings Accounts.[15]

Flexible Spending Accounts-Flexible Spending Accounts are employer established benefit plans that reimburse employees for specified expenses as they are incurred. The end-of-year balances are subject to the "use it or lose it" rule, where the remaining money is forfeited to the employer. Nonmedical withdrawals are not permitted. These plans may be used to pay for unreimbursed health care expenses, but are not coupled with a high-deductible health plan, and are not considered a consumer-driven health plan.[16]

Medical Savings Accounts-Medical Savings Accounts[17] are precursors to HSAs. These plans are less attractive than the HSA because the minimum deductible for the high deductible health plan is higher. The deductible for individual coverage is $1,750 and family coverage is $3,500. The minimum deductible for an HSA is $1,000 for individual coverage and $2,000 for family coverage. Nonmedical withdrawals are permitted with a 15 percent penalty. As of December 15, 2005, no new Medical Savings Accounts may be created. Current account holders may continue to contribute to their accounts as long as the account is still linked to a high deductible health plan. Account holders may roll their account balance over into a new account, such as an HSA.[18]

Health Reimbursement Arrangements-Health Reimbursement Arrangements are funded only by employer contributions and are owned by the employer, not the consumer. So, if an employee leaves a job, they usually forfeit their account balance. Unlike HSAs, under Health Reimbursement Arrangements employers do not payout until an employee makes a claim. This provides employers greater control over employees' health care expenditures.[19] Nonmedical withdrawals are not permitted, and these types of plans do not need to be associated with high deductible health plans. However, employers generally couple a health reimbursement arrangement with a

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[14] Lyke, Bob, Chris Peterson and Neela Ranade. 2005. "Health Savings Accounts." Congressional Research Service, The Library of Congress. http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3246703232005.pdf (November 29, 2005).

[15] Chaikind, Hinda and Fran Larkins. 2005. "Health Insurance Coverage for Retirees." Congressional Research Service. The Library of Congress. http://www.opencrs.cdt.org/document/RL32944/ (November 29, 2005).

[16] Ibid.

[17] These accounts were authorized as a demonstration under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). They were renamed Archer MSAs by P.L. 106-554.

[18] Chaikind, Hinda and Fran Larkins. 2005. "Health Insurance Coverage for Retirees." Congressional Research Service. The Library of Congress. http://www.opencrs.cdt.org/document/RL32944/ (November 29, 2005).

[19] Marchetta, Monica and Deborah Rogel. 2005. "Issue Brief: Health Savings Accounts as a Tool for Market Change." Vol. 8. No. 4. Academy Health. http://www.hcfo.net/pdf/issue0605.pdf (November 29, 2005).

health insurance plan. The insurance premium is usually higher than the employers' annual contribution and requires the employee to supplement the difference.[20]

Health Savings Accounts-A health savings account (HSA) is a savings account combined with a high-deductible health insurance plan. Individuals own the account and are allowed to deposit tax-deductible funds into it to cover current and future medical expenses.[21]

HEALTH SAVINGS ACCOUNTS

HSAs are in their infancy. Americans gained access to health savings accounts on January 1, 2004. The framework for health savings accounts was established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, commonly referred to as the "MMA." The MMA provided for a voluntary program for prescription drug coverage under the Medicare Program (Medicare Part D), and amended the Internal Revenue Code of 1986 to allow a tax deduction for amounts contributed to health savings accounts.[22]

The concept of health savings accounts can be traced as far back as 1984 with the idea of individually owned "medical IRAs." By 1990, the National Center for Policy Analysis had organized a taskforce of over 40 think tanks, universities and research organizations which collaborated on a report advocating the need for self-insurance of small medical bills through "medisave" accounts. The "medisave" accounts were later referred to as medical savings accounts. The work of the taskforce was expanded in the book, *Patient Power*, published in 1992.[23]

By 1992, legislators on Capitol Hill had filed 12 different bills containing language to create medical savings accounts. The bills received the support of 150 cosponsors, both conservatives and liberals. Initially, Medical Savings Accounts (MSAs) were at a disadvantage due to the tax laws. The MSAs were subject to income and payroll taxes, and unspent funds could not be rolled over nor earn tax-free interest. In 1996, Congress approved a pilot program that allowed tax free accounts for the self-employed and small businesses. Due to numerous restrictions and plan design the pilot program was not successful. The pilot had a cap of 750,000 plan policies but only a tenth of the plans were purchased. The MSA plan was restructured and the current design of the health savings account emerged.[24]

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[20] Chaikind, Hinda and Fran Larkins. 2005. "Health Insurance Coverage for Retirees." Congressional Research Service, The Library of Congress. http://www.opencrs.cdt.org/document/RL32944/ (November 29, 2005).
[21] United States Department of the Treasury. Office of Public Affairs. 2005. "Health Savings Accounts." http://www.treas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-05.pdf. (November 28, 2005).
[22] National Center for Policy Analysis. 2004. "A Brief History of Health Savings Accounts." http://www.ncpa.org/pub/ba/ba481 (August 13, 2004).
[23] Ibid.
[24] Ibid.

Popularity of Health Savings Accounts

According to a 2003 survey of employer-sponsored health plans, interest in HSAs is high, especially among very large and very small employers; 81 percent of large and 78 percent of small employers surveyed indicated their interest in implementing an HSA by 2006.[25] Findings from the March 2005 America's Health Insurance Plans survey suggests that insurers are responding to employers and individual interests and have entered the HSA market.[26] The survey found that over 1 million people were covered by a Health Savings Account linked to a high deductible health plan. This is double the enrollment rate reported in September 2004.[27] An estimated two percent of the health plan market is comprised of HSAs and HRAs.[28] The survey also suggests that HSAs are a potential tool to address the problem of the uninsured. The survey revealed that 37 percent of the policies sold on the individual market were purchased by individuals who were previously uninsured.

ADVANTAGES OF HEALTH SAVINGS ACCOUNTS

The advantages of putting money into an HSA include tax savings, flexibility, portability and consumer control.

Tax Savings with HSAs-An HSA provides participants the ability to receive several tax savings. They are:

- Tax deductions when participants contribute to their own account.
- Tax-free earnings through investments.
- Tax-free withdrawals for qualified medical expenses.

Flexibility of HSAs-An HSA provides flexibility that is not available with traditional insurance plans. Individuals may decide to pay for current medical expenses including items not covered by insurance, or the money may be saved for the future. Future expenses may include:

- Health insurance or medical expenses if unemployed.
- Medical expenses after retirement and prior to receiving Medicare.
- Out-of-pocket expenses when covered by Medicare.
- Long-term care expenses and insurance.

While planning for the future, the money in an HSA may grow through investment earnings similar to an IRA (Individual Retirement Account).

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[25] Mercer Human Resources Consulting. 2004. "National Survey of Employer-Sponsored Health Plans: 2003 Survey Report."
[26] Yoo, Hannah and Teresa Chovan. 2005. "Number of HSA Plans Exceeded One Million in March 2005," America's Health Insurance Plans. Center for Policy and Research. http://www.ahip.org/content/fileviewer.aspx?docid=9771&linkid=83197. (November 28, 2005).
[27] Ibid.
[28] Reece, Richard, MD. 2004. "Observing Healthcare Consumer-Driven Care: Eight Directions for 2005." HealthLeaders News. http://www.healthleaders.com/news/print.php?contentid=60781(December 7, 2004).

Portability of HSAs-Unlike many insurance plans, HSAs are portable and move with the individual. If a person changes jobs, changes medical coverage, moves to another state, or becomes unemployed they still have access to their HSA.

Consumer Control of HSAs-The funds in an HSA are controlled by the individual account holder. Employers and HSA trustees are not required to determine whether HSA distributions are used exclusively for qualified medical expenses.[29] HSAs allow disbursements for nonmedical purposes, although such spending is subject to income tax, and for individuals under the age of 65, a 10 percent penalty.[30] The account holder determines the amount of money put into the account; whether to save the account for future expenses or pay current medical expenses; which company will hold the account; and whether to invest any of the money in the account. This encourages account holders to spend their funds more wisely, and encourages them to shop around for the best value for their health care dollars.

The funds in an HSA can remain in an account from year to year. There are no "use it or lose it" provisions. Unspent balances in accounts remain in the account until they are spent. HSA accounts have the flexibility of being passed on to beneficiaries and becoming part of an estate.[31]

Eligibility for Health Savings Accounts

In order to be eligible for an HSA, an individual must not be covered under any other health plan. Other supplemental plans are potentially exempt from this restriction if they cover any of the following items:[32]

- Accidents;
- Disability;
- Dental care;
- Vision care;
- Long-term care;
- Benefits related to workers' compensation laws, tort liabilities, or ownership or use of property;
- A specific disease or illness; or
- A fixed amount per day (or other period) of hospitalization.

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[29] Perrin, Towers. 2004. "Consumer-directed Care: Side-by-side comparison of HSAs and HRAs." AIS Consumer-directed Care. http://www.aishealth.com/ConsumerDirected/CDdata/sidebysideHSA.html (July 25, 2005).

[30] Walsh, Tom. 2004. "Risk Alert: Controlling Health Care Costs." Marsh. Health Care Costs. Vol. 3. Issue 3. http://www.marshweb.com/MarshPortal/resources?id=5610ad7730204bff9225db54f4d61d10 (November 28, 2005).

[31] United States Department of the Treasury. Office of Public Affairs. 2005. "Health Savings Accounts." http://www.treas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-05.pdf. (November 28, 2005).

[32] United States Department of the Treasury. Internal Revenue Service. 2004. "Tax Law Changes for Individuals." http://www.irs.gov/formspubs/article/0,,id=109876,00.html#hsa_2004 (September 26, 2005).

Further, in order to be eligible for an HSA, individuals may not be claimed as a dependent on another person's tax return, though they may be a spouse filing jointly.

High Deductible Health Plans Required with a Health Savings Account

HSAs are used in conjunction with a qualified high deductible health plan. A high deductible health plan is insurance that does not generally cover "first dollar" coverage for health care expenses.

Federal law[33] requires that in order for a plan to qualify as a high deductible plan it must have a deductible of at least:

- $1,000 for individual coverage
- $2,000 for family coverage

For 2004[34], the annual out-of-pocket expenses, including deductibles, co-payments, and co-insurance may not exceed:

- $5,100 for individual coverage
- $10,200 for family coverage

Preventative Care and High Deductible Health Plans

Preventative care is considered an optional coverage area for high deductible health plans. Plans that include preventative care have the option to pay for services on a first-dollar basis before the minimum deductible is satisfied, and may or may not require a co-payment. Depending on the plan, preventative care may include services such as annual physicals, routine pre-natal and well-child care, child and adult immunizations, tobacco cessation and weight loss programs, and screening services such as mammograms.[35] Certain drugs and medications may be considered preventative care, such as drugs that prevent the reoccurrence of a disease or drugs that are taken by an individual who has developed the risk factors for a particular disease.

PROBLEMS FACING HEALTH SAVINGS ACCOUNTS

Risk Selection and Health Savings Accounts

According to the plans that participated in the Mercer/Harvard study, the verdict on risk selection is mixed. One plan found that healthier patients were selecting consumer-driven plans over traditional Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) options. Another plan found that enrollees were slightly sicker than average. Many plans have reported that the type of employer that chooses

[33] Section 223 of the Internal Revenue Code.
[34] The annual out-of-pocket maximum amounts are set to increase annually to reflect inflation rates.
[35] United States Department of the Treasury. Office of Public Affairs. 2005. "All about HSAs." http://www.treas.gov/offices/public-affairs/hsa/pdf/hsa-basics.pdf (November 2, 2005).

to offer a consumer-driven plan is also highly varied, and includes many industries or businesses with predominantly low-wage employees.[36]

Conflicts with State Benefit Mandates

States that mandate first dollar coverage for certain conditions or services are problematic for high deductible health plans that are linked to health savings accounts. A high deductible health plan can lose the tax deferred status of the health savings account if a state mandates first dollar coverage. From January 1, 2004 until January 1, 2006, a transition period exists. Plans with mandated first dollar coverage will not lose their tax status during this period. After the transition period, plans will lose their tax status if first dollar coverage remains in place.[37] In 2005, the Florida Legislature provided an exemption from this mandate for health plans that offer a health savings account with a qualified high-deductible health plan.[38]

Variable Employer Contributions to Health Savings Accounts

Employer contributions to HSAs are voluntary. For this reason, small employers may adopt HSAs instead of a traditional health plan simply to continue to provide health benefits to their employees. This enables them to offer HSAs without making a contribution to the account, making it a less useful savings tool for future and retiree health expenses.[39]

The amount contributed to a health savings account by an employer varies by the nature of the coverage and the age of an employee. Employers must report contributions to an employee's HSA account on the employees W-2 form. With individual coverage, the individual (or employer) may contribute up to the amount of the annual health plan deductible, but not more than $2,650 in 2005 ($3,100 if age 55 or older).[40] For individuals needing family coverage, the individual (or employer) can contribute up to the amount of the annual health plan deductible, but not more than $5,250 in 2005 ($5,650 if age 55 or older).[41]

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[36] U.S. Congress. Joint Economic Committee Testimony. 2004. "Consumer Directed Health Benefit Plans Could Greatly Improve Quality of Care and Health Insurance Affordability; Early Attempts will Fall Considerably Short of Their Potential; There are Budget-Neutral Opportunities for Congress to Help." 108th Congress. http://jec.senate.gov/democrats/Documents/Hearings/milsteintestimony25feb2004.pdf (November 29, 2005).

[37] United States Department of the Treasury. Office of Public Affairs. 2005. "All about HSAs." http://www.treas.gov/offices/public-affairs/hsa/pdf/hsa-basics.pdf (November 2, 2005).

[38] See s. 627.413 (6), F.S.

[39] Marchetta, Monica and Deborah Rogel. 2005. "Issue Brief: Health Savings Accounts as a Tool for Market Change." Vol. 8. No. 4. Academy Health. http://www.hcfo.net/pdf/issue0605.pdf (November 29, 2005).

[40] United States Department of the Treasury. Internal Revenue Service. 2004. "Tax Law Changes for Individuals." http://www.irs.gov/formspubs/article/0,,id=109876,00.html#hsa_2004 (September 26, 2005).

[41] Ibid.

Individuals must have the insurance all year to contribute the maximum amount. The contribution amount is reduced to reflect any time not covered.[42]

CONSUMER-DRIVEN HEALTH PLANS

Providing ample choices to consumers is instrumental to the success of consumer-driven health care. In order to succeed health plans must take into consideration how consumers make informed health care decisions.

Health Care Choices and Decision Making

According to Academy Health, "An assumption underlying consumer-directed health care is that patients change consumption based on the availability of health care choices. Some argue that health care consumption is driven more by unpredictable events than by calculated and well-thought-out decisions."[43] "Consumer education, communication, and transparency of information are necessary in order to encourage educated, proactive, and cost-conscious consumers. If health care consumers cannot or do not make rational decisions, the long-term cost and quality impacts of consumer-directed health care could be negative."[44]

Lack of Information

The Mercer/Harvard Study found gaps that limit the efficiency and effectiveness of consumer-driven health benefit plans. These gaps include:

(1) Limited information that is valid and provides easily understood performance comparisons among physicians, among hospitals by specific service lines, and among treatment options;[45] and

(2) A lack of available research that provides evidence of the form and size of incentives required to motivate consumers.[46]

Health Literacy and Decision Making

Studies have found that it is challenging for consumers to make rational decisions about their health insurance and it is nearly impossible for the millions of Americans to understand the connection between health insurance and medical decision-making.[47]

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[42] Ibid.
[43] Marchetta, Monica and Deborah Rogel. 2005. "Issue Brief: Health Savings Accounts as a Tool for Market Change." Vol. 8. No. 4. Academy Health. . http://www.hcfo.net/pdf/issue0605.pdf (November 29, 2005).
[44] Ibid.
[45] U.S. Congress. Joint Economic Committee Testimony. 2004. "Consumer Directed Health Benefit Plans Could Greatly Improve Quality of Care and Health Insurance Affordability; Early Attempts will Fall Considerably Short of Their Potential; There are Budget-Neutral Opportunities for Congress to Help." 108th Congress. http://jec.senate.gov/democrats/Documents/Hearings/milsteintestimony25feb2004.pdf (November 29, 2005).
[46] Ibid.
[47] Ibid.

Decision making requires skills in several areas: being able to correctly interpret data; weighting factors in ways that match one's individual needs; making trade-offs; and bringing all of the factors together into a choice.[48] Studies have shown that the weakest decision making skill is correctly interpreting comparative data.[49]

A study on Medicare Informed-Choice revealed that older adults seek less information and exhibit less sophisticated reasoning when making decisions.[50] The study also revealed that among the Medicare group, those in poorer health, with less education, and who were older, tended to make more errors. Those who made more errors were also less likely to seek help when making a health plan decision. Individuals with poor comprehension skill indicated a greater willingness to delegate decisions, but were not likely to seek decision making assistance.

The study concluded that comprehension skill level is linked to attitudes about decision making, desire for choice, and preferences with regard to the delegation choices, for both the elderly and non-elderly consumers. All individuals, who have poorer comprehension skills, regardless of the age, viewed more information and options as an unwelcome burden.[51]

Information Seeking and Web-based Consumer Education

Understanding how information is sought is critical to the success of consumer-driven health plans. A 2001 survey of US households found that only 38 percent of adults, or 72 million people, sought health information in the previous year from a source other than their doctor.[52] According to the survey, one in six consumers turned to the Internet for health information. One in four adults relied on books or magazines and 20 percent turned to friends or relatives for health information. Half of all people with chronic health conditions sought no health information. The PEW Foundation found that "twenty-two percent of American adults have never used the Internet and do not live in households with Internet access."[53]

An individual's level of education is a major predictor as to whether he or she will seek health information. Information seeking rises sharply as the level of education

[48] Hibbard, Judith, Paul Slovic and et al. 2001. "Is the Informed-Choice Policy Approach Appropriate for Medicare Beneficiaries?" Health Affairs. http://content.healthaffairs.org/cgi/reprint/20/3/199.pdf (October 13, 2005).
[49] Ibid.
[50] Ibid.
[51] Ibid.
[52] Tu, Ha T. and J.Lee Hargraves. 2003. "Seeking Health Care Information: Most Consumers Still on the Sidelines." Center for Studying Health System Change. No. 61. March 2003. http://www.hschange.org/CONTENT/537 (November 18, 2005).
[53] Fox, Susannah. 2005. "Digital Divisions: There are clear differences among those with broadband connections, dial-up connections, and no connections at all to the internet." Pew Internet & American Life Project. http://www.pewinternet.org/PPF/r/165/report_display.asp (October 5, 2005).

increases.[54] Other predictors are gender, age, and socioeconomic status. Men are less likely than women; older consumers are less likely than younger; and individuals with lower income are less likely than higher income people to seek health information. Minority consumers are somewhat less likely than white consumers to use the Internet as a health information source.[55]

Some analysts caution that the success of consumer tools depends mainly on the physician-patient communication. These relationships can be so strong that some believe patient-information systems will not influence consumer decisions.[56]

USE OF QUALITY INDICATORS AND CONSUMER COMPARISON TOOLS

Many consumer-driven health plans are creating consumer comparison tools that are based on predetermined quality indicators. There is a wide array of approaches in determining quality indicators. Some plans have created pharmacy tools that enable members to compare drug costs and search for prescription-drug alternatives. Other plans focus on allowing members to search for physicians by specialty and location, find personal information on a physician, or see quality ratings that are based on consumer satisfaction surveys. Unfortunately, quality indicators vary greatly, as does the data. Many companies' indicators and comparison tools are proprietary, which limits the opportunity for consumers to readily compare data across health plans, hospitals, or physicians.

The State of Florida is addressing this problem by providing comparison tools for consumers to assist them in making well-informed health care decisions. The Agency for Health Care Administration and the Attorney General's office launched a prescription drug cost comparison website[57] called "The Florida Prescription Drug Price."[58] The Florida Department of Financial Services has also launched a prescription drug price comparison tool on a Senior Resource Center website.[59] A new Florida Compare Care website,[60] required by s. 408.05, F.S., allows consumers to compare performance data[61] and information on selected medical conditions and procedures in Florida's short-term acute care hospitals and ambulatory (outpatient) surgery centers.

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[54] Tu, Ha T. and J.Lee Hargraves. 2003. "Seeking Health Care Information: Most Consumers Still on the Sidelines." Center for Studying Health System Change. No. 61. March 2003. http://www.hschange.org/CONTENT/537 (November 18, 2005).
[55] Ibid.
[56] Marchetta, Monica and Deborah Rogel. 2005. "Issue Brief: Health Savings Accounts as a Tool for Market Change." Vol. 8. No. 4. Academy Health. . http://www.hcfo.net/pdf/issue0605.pdf (November 29, 2005).
[57] http://www.myfloridarx.com/
[58] The Florida Prescription Drug Price website provides pricing information for the 50 most commonly used prescription drugs in Florida. The prices are the "usual and customary prices," also known as retail prices, reported monthly by pharmacies.
[59] http://www.flseniors.net/prescriptiondrugs/
[60] http://www.floridacomparecare.gov
[61] The website reports "administrative data" which includes hospital billing data, and provides information on each patient's illness or condition, procedures performed and the patient's condition at discharge.

Report Cards

Health care report cards publicly report information on quality indicators for physicians, hospitals, and health plans to act as a comparison tool for consumers in the hopes of motivating health care providers to improve their performance and quality of care.

A study released by the Agency for Healthcare Research and Quality of the US Department of Health and Human Services, found the value of publicly reported quality information is largely undemonstrated and may inadvertently reduce, rather than improve, quality of care because information about outcomes may cause doctors to avoid treating high risk patients.[62] The study suggests including measures on the appropriateness of care and the processes of care rather than on a patient's outcome to improve the value of the report card.[63] The researchers suggest that releasing the information only to physicians who are being rated might encourage them to improve their performance without giving them an incentive to avoid patients they perceive as being high risk.[64]

One example of widely used performance measures is the HEDIS (Health Plan Employer Data and Information Set) developed as a standardized set of measures for health plans by the National Committee for Quality Assurance, which was released in 1996. HEDIS contains over 60 criteria describing plan performance in key areas of interest to consumers: quality of care, access to care, and patient satisfaction. The HEDIS criteria allow consumers to compare the quality of care and other descriptive information about a particular plan. HEDIS does not provide an overall ranking, but allows consumers to make choices based on what is important to them.

Consumer Satisfaction

Gauging consumer satisfaction is based on the evaluation of subjective survey results. Surveys may ask consumers to rank or rate a physician, hospital, or plan based on their personal experience. Questions that may be included on a survey include: what do they think of the health professionals they saw; how well they believe they were cared for; whether they would recommend their health plan to others; whether they intend to stick with their health plan or switch; and what is their overall level of satisfaction. Critics argue that a consumer's opinion may be skewed by various factors.

Quality Data and Discharge Information

The Centers for Medicare & Medicaid Services (CMS), the U.S. Department of Health and Human Services along with the Hospital Quality Alliance[65] have collaborated to

[62] Werner, Rachel M., M.D., Ph.D., and David A. Asch, M.D., M.B.A. "Publicly reporting quality information may inadvertently reduce, rather than improve, care quality." Agency for Healthcare Research and Quality. Research Activities. No. 299. http://www.ahcpr.gov/research/jul05/0705RA4.htm (July 2005).
[63] Ibid.
[64] Ibid.
[65] In December 2002, the American Hospital Association, Federation of American Hospitals, and Association of American Medical Colleges launched the Hospital Quality Alliance, a national public-

create a website for the comparison of hospitals. The Hospital Quality Alliance promotes reporting hospital quality of care in an effort to make hospital performance information more accessible to the public, payers, and providers of care.[66] Their collaboration is intended to make important information about hospital performance accessible to the public to inform consumers and invigorate efforts to improve quality. The comparison data is voluntarily submitted for public disclosure and is posted on the US Department of Health and Human Services website.[67] Beginning in 2004, eligible hospitals can elect to report quality data and receive an incentive payment established by Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. In order for hospitals to obtain the incentive, eligible hospitals are required to report on at least 10 of the initial sets of quality performance measures and to agree to have their data publicly displayed.[68]

Billing Data and Unit Price

The Mercer/Harvard study found that currently most health plan comparisons are based on hospital billing data or unaudited hospital survey responses to measure quality and cost comparisons. According to Dr. Arnold Milstein's testimony, "the consensus of the scientific community and a recent measure endorsement process by the National Quality Forum is that hospital billing data is generally an inadequate basis on which to compare hospital quality. Cost comparisons that are reported are usually based on the unit price charged by the physician, hospital, or pharmacy, rather than on their longitudinal cost-efficiency."[69] The use of unit price as an index of cost-efficiency is problematic because researchers have independently documented that they are misleading signals of relative cost-efficiency.[70] Lower unit prices typically induce physicians to provide a greater volume of services, either services billed by them or by others, such as laboratories, radiologists, or hospitals.[71] Many health plans are also unable to make statistically valid comparisons between individual doctors or hospital service lines due to a lack of claims experience.[72]

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private collaboration to encourage hospitals to voluntarily collect and report hospital quality performance information.

[66] "Hospital Quality Overview," Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (DHHS) and Hospital Quality Alliance http://www.hospitalcompare.hhs.gov/Hospital/Static/About-Overview.asp?dest=NAV|Home|About|Overview#TabTop (October 17, 2005).

[67] http://www.hospitalcompare.hhs.gov/hospital/home2.asp

[68] "Hospital Quality Overview," Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (DHHS) and Hospital Quality Alliance http://www.hospitalcompare.hhs.gov/Hospital/Static/About-Overview.asp?dest=NAV|Home|About|Overview#TabTop (October 17, 2005).

[69] U.S. Congress. Joint Economic Committee Testimony. 2004. "Consumer Directed Health Benefit Plans Could Greatly Improve Quality of Care and Health Insurance Affordability; Early Attempts will Fall Considerably Short of Their Potential; There are Budget-Neutral Opportunities for Congress to Help." 108th Congress. http://jec.senate.gov/democrats/Documents/Hearings/milsteintestimony25feb2004.pdf (November 29, 2005).

[70] Ibid.

[71] Ibid.

[72] Ibid.

Consumer incentives to select cost-efficient options are concentrated at the low end of annual per capita health care costs.[73] Roughly 55% of total commercial health insurance spending is by enrollees who exceed their annual out-of-pocket limits. This limits the health care cost savings of most early consumer-driven plans because costlier consumers did not have an incentive to save.

CONCLUSION

Consumer-driven health care covers a wide range of opportunities and issues within the health care industry. The most popular type of consumer-driven plan is the Health Savings Accounts (HSAs), which are in their infancy. HSAs could number 8.2 million, and hold $50 million in assets by the end of 2010. There are many advantages to HSAs. The funds in an HSA can remain in an account from year to year. There are no "use it or lose it" provisions and HSAs have the flexibility of being passed on to beneficiaries and becoming part of an estate. Employer interest in HSAs is high, 81 percent of large and 78 percent of small employers surveyed indicated their interest in implementing an HSA by 2006.

Because HSAs are in their infancy, there are still many issues to address. Too many health care options may confuse consumers. HSAs enable employers to offer a health care plan to employees but do not require employers to contribute to the plans. HSAs may be susceptible to adverse selection by attracting healthier and wealthier individuals. Policy makers in the field suggest that more research needs to be conducted to identify what type and size of incentives encourage consumers to become more active participants in health care decision making.[74] The healthcare industry needs to develop a more 'universal' comparison tool, enabling consumers to compare cost, quality and performance indicators across plans and providers.

[73] Ibid.

[74] The University of Minnesota was recently awarded a grant by the Robert Wood Johnson Foundation (RWJF) to study "The impact of Consumer Health Plan Decision Support Tools on Health Plan Choice and Quality." The National Conference of State Legislatures competed for the same grant, but they were not awarded the grant. According to NCSL staff, they will continue to study the issue of consumer choice and incentives.